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clinical practice

Sigma adenocarcinoma and a scalp lipoma: skin metastases from colorectal cancer

G. QUERINI, S. ZONTA, T. DOMINIONI

SUMMARY: **Sigma adenocarcinoma and a scalp lipoma: skin metastases from colorectal cancer.**

G. QUERINI, S. ZONTA, T. DOMINIONI

Skin metastases from colorectal cancer are a rare phenomenon that occurs only in 4,4% of cases. The presence of a cutaneous lesion at the time of diagnosis is even more uncommon (0,05% of cases), and represents a sign of widespread, poor prognosis and terminal disease. Skin involvement by colorectal cancer can occur in four different pathways: lymphatic, hematogenous, direct invasion of contiguous tissues or iatrogenic implantation. We describe a case of a 68-year-old patient affected by a pT4b pN1 M1 sigma carcinoma with a head lesion that, at the time of diagnosis, mimics a lipoma at the head CT scan.

KEY WORDS: Colorectal cancer - Tumor - Skin/cutaneous metastases.

Introduction

The occurrence of skin metastases from internal tumors is a rare event. Every cancer can involve the cutaneous tissue, but the primary lesion location and its histologic type affect the frequency and the site of skin metastases. According to the literature (1), melanoma, breast cancer and nasopharyngeal carcinoma are the tumors that most frequently involve the skin, while colorectal tumor metastasizes to cutaneous tissue only in 4,4% of cases. At the time of the diagnosis of primary malignancy, skin lesions are uncommon (1,3%) and can be classified as a direct invasion or as a distant metastasis (2). At the time of the diagnosis, a colorectal cancer affects the cutaneous tissue only in 0,05% of cases (1, 2) and it is frequently localized to the abdominal wall, pelvis, upper extremities, chest, back, head and neck, in order of decreasing frequency (3, 4).

Case report

A 68-year-old man patient was admitted to the ER Department for recurrent abdominal pain and weight loss. Personal history reported obesity, a resolved pneumonia and bilateral saphenectomy.

Abdominal CT scan revealed enlargement of sigma wall, pathological loco-regional lymph nodes and liver metastases in S5, S6 and S4b. Biopsy performed during colonoscopy was suggestive of adenocarcinoma. To complete the pre-operative metastatic work-up, a thorax and brain CT were performed. These exams reported only a head lipoma without any sign of extra abdominal tumor diffusion (Figure 1).

Patient underwent a surgical videolaparoscopic resection of sigma, bladder and small bowel involved by the tumor growth. During the surgical procedure we removed also the voluminous head lesion that caused discomfort to the patient (Figure 2).

Surgical specimens histological examination reported a pT4b pN1 (metastases in 1 of 20 lymph nodes collected) badly differentiated carcinoma that involved all intestinal wall, exceeded the serosa and infiltrated the small bowel and the bladder. There was also perineural and vascular (lymphatic) inva-

Fondazione IRCCS Policlinico San Matteo, General Surgery, Pavia, Italy

Corresponding author: Giorgio Querini, e-mail: giorgio.querini@gmail.com

Figure 1 - Brain CT scan reported a scalp lipoma.

Figure 2 - Voluminous scalp lesion.

sion. Immune profile: ck AE1 AE3 +; ck7 -, ck20 -; ck19 +/-; S100 -; BetaHCG -; MLH 1 -. None KRAS, NRAS and BRAF mutation were found.

Head skin lesion histopathological analysis revealed a 3,4 x 3,4 x 2,0 cm metastasis from a colonic badly differentiated carcinoma with clear excision margins.

Subsequently the patient underwent a palliative therapy.

Discussion

Skin metastases from colorectal cancer are a rare phenomenon that occurs only in 4,4% of cases (1). Generally, they are evidence of recurrence of cancer and represent the failure of adjuvant therapy after a surgical resection. Rarely a cutaneous lesion is the first sign of an undiagnosed tumor, even if in literature no data are available.

The presence of a cutaneous lesion at the time of diagnosis is even more uncommon (0,05% of cases) (1, 2) and represents a sign of widespread, poor prognosis and terminal disease (5, 6).

Cutaneous metastases often involve the middle or lower dermis and mimic lipomas, granulomas, neurofibromas and cysts, as asymptomatic intradermal nodules (7). Skin metastases early detection affects the prognosis and the treatment (7).

Skin involvement by colorectal cancer can occur in four different pathways: lymphatic, hematogenous, direct invasion of contiguous tissues or iatrogenic implantation, as can happen during surgical procedures (8, 9). However, only the lymphatic and the hematogenous pathways represent a true metastatic diffusion.

The skin lesion developed by our patient is sited very distant from the primary cancer. The histopathological analysis reported a vascular (lymphatic) invasion by the tumor, although only 1 of the 20 collected lymph nodes was involved by cancer. These data suggest a lymphatic or, more likely, hematogenous cancer spread.

Conclusion

Although skin metastases are rare, in a patient affected by internal cancer every skin lesion should be considered a sign of neoplasm. An asymptomatic firm, rubbery intradermal or subcutaneous node, that mimic cysts, granuloma or lipoma, can be a mark of tumor spread. A meticulous research of skin lesion in neoplastic patient is very important. Indeed, an early detection of cutaneous tissue involvement by the tumor affects the tumor staging, the prognosis and the therapeutic strategy.

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